ROCKY MOUNTAIN SPOTTED FEVER CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 52684 (6-06)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name _____ **ISDH Action:** ○ A case ○ Not a case

First Name _____ **MI** _____ **Phone Number** _____ - _____ - _____

Number & Street Address _____

City _____ **State** _____ **ZIP Code** _____ - _____

County _____ **Date of Birth** ___ / ___ / _____ **Age** _____

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation _____ **Phone of Employer/School/Day Care** _____ - _____ - _____

Name of ○ Employer ○ School ○ Day Care _____

Address of Employer/School/Day Care _____

City _____ **State** _____ **ZIP Code** _____ - _____

Section 2. Clinical Information

Symptoms (check all that apply):

- ○ Fever _____ . _____ *(degrees)*
- ○ Myalgia
- ○ Headache
- ○ Nausea
- ○ Vomiting
- ○ Abdominal Pain/Tenderness
- ○ Diarrhea

Rash
- ○ - Wrist
- ○ - Ankles
- ○ - Palm
- ○ - Trunk
- ○ - Soles
- ○ Photopobia
- ○ Other, specify: _____

Date of Illness Onset ___ / ___ / ___

Date of Rash Onset ___ / ___ / ___

Duration of Symptoms in Days _____

Date First Positive Specimen Collected ___ / ___ / ___

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Section 2. Clinical Information (continued)

Laboratory Results:

CSF exam performed?

○ Yes ○ No

__/__/__
If Yes, date performed

Lymphocytes count **Neutrophils count** **Eosinophils count** **Basophils count**

CBC performed?

○ Yes ○ No

If Yes, results:

Thrombocytes count **WBC count** **Neutrophils count** **Lymphocytes count**

Biopsy (immunohistochemical)?

○ Yes ○ No

If Yes, results: ○ Positive ○ Negative

Serological (check test type):

○ Indirect Immunofluorescence ○ Latex Agglutination ○ Enzyme-Linked Immunosorbent Assay

1. IgM Testing

__/__/__
Acute Specimen Taken

Acute Value

__/__/__
Convalescent Specimen Taken

Convalescent Value

Results:

○ Significant Rise in IgM
○ No Significant Rise in IgM
○ Pending
○ Not Done
○ Indeterminate
○ Unknown

2. IgG Testing

__/__/__
Acute Specimen Taken

Acute Value

__/__/__
Convalescent Specimen Taken

Convalescent Value

Results:

○ Significant Rise in IgG
○ No Significant Rise in IgG
○ Pending
○ Not Done
○ Indeterminate
○ Unknown

Other test results:

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code** -

__-__-__
Physician/Hospital Phone

Was the patient hospitalized before or during infection?

○ Yes ○ No

If Yes, admission date: __/__/__

Discharge date: __/__/__

Hospital:

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Section 3. Risk Factors

Was the patient treated with antibiotics after onset?

○ Yes ○ No ○ Unknown

If Yes, antibiotic

Date started / / **Date ended** / /

Did patient die?

○ Yes ○ No

Patient's home setting:

○ Urban ○ Suburban ○ Rural

During the three weeks prior to symptoms, did the patient:

Engage in outdoor activities at home?

○ Yes ○ No

If Yes, describe

Date / /

Engage in any of the following activities (check all that apply)?

○ Camping ○ Hiking ○ Fishing ○ Picnicking ○ Hunting

If so, where

Date / /

Travel to recreational areas within county of residence?

○ Yes ○ No

If Yes, where

Date / /

Travel outside of county of residence but within Indiana?

○ Yes ○ No

If Yes, where

Date / /

Travel outside of Indiana?

○ Yes ○ No

If Yes, where

Date / /

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Section 3. Risk Factors (continued)

Stay overnight away from home?

○ Yes ○ No

If Yes, where

Date

During the four weeks prior to symptoms, did the patient:

Sustain any known tick bites?

○ Yes ○ No

If Yes, date

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number **Date**